

<i>SERFF Tracking Number:</i>	<i>UHLC-126803176</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>UnitedHealthcare of Arkansas, Inc.</i>	<i>State Tracking Number:</i>	<i>46730</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>2001 PPACA Amendment</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.		
Product Name: 2001 PPACA Amendment	SERFF Tr Num: UHLC-126803176	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 46730
	Co Tr Num:	State Status: Approved-Closed
Sub-TOI: H21.000 Health - Other		Reviewer(s): Rosalind Minor
Filing Type: Form	Author: Ebony Terry	Disposition Date: 09/16/2010
	Date Submitted: 09/08/2010	Disposition Status: Approved-Closed
		Implementation Date:
Implementation Date Requested: On Approval		
State Filing Description:		

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 09/16/2010	Explanation for Other Group Market Type:
	State Status Changed: 09/16/2010
Deemer Date:	Created By: Ebony Terry
Submitted By: Ebony Terry	Corresponding Filing Tracking Number:
PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms	
Filing Description:	
2001 PPACA Amendment	

Company and Contact

Filing Contact Information

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SERFF Tracking Number: UHLC-126803176 State: Arkansas
 Filing Company: UnitedHealthcare of Arkansas, Inc. State Tracking Number: 46730
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 Product Name: 2001 PPACA Amendment
 Project Name/Number: /
 Rockville, MD 20850

Filing Company Information

UnitedHealthcare of Arkansas, Inc.	CoCode: 95446	State of Domicile: Arkansas
Plaza West Building	Group Code:	Company Type: HMO
415 North McKinley Street, Suite 300	Group Name:	State ID Number:
Little Rock, AK 72205	FEIN Number: 63-1036819	
(952) 992-7428 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	1 form x 50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	\$50.00	09/08/2010	39308138

SERFF Tracking Number:	UHLC-126803176	State:	Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/16/2010	09/16/2010

SERFF Tracking Number: *UHLC-126803176*

State: *Arkansas*

Filing Company: *UnitedHealthcare of Arkansas, Inc.*

State Tracking Number: *46730*

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TOI: *H21 Health - Other*

Sub-TOI: *H21.000 Health - Other*

Product Name: *2001 PPACA Amendment*

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Disposition

Disposition Date: 09/16/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: UHLC-126803176

State: Arkansas

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TOI: H21 Health - Other

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	PPACA	Approved-Closed	Yes

SERFF Tracking Number:	UHLC-126803176	State:	Arkansas
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Company Tracking Number:			
TOI:	H21 Health - Other	Sub-TOI:	H21.000 Health - Other
Product Name:	2001 PPACA Amendment		
Project Name/Number:	/		

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/16/2010	PPACAAM D.H.01.AR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	PPACA	Initial			X10H_AMD_ Reform_2001 Series.pdf

Patient Protection and Affordable Care Act (PPACA) Amendment [UnitedHealthcare of Arkansas, Inc.]

As described in this Amendment, the Policy is modified as stated below.

Plan [Para] Contract Issuance: Include only if the Amendment is to be mailed separate from the COC and if the 2001 series is modified by other amendments. Do not include when amendment is issued as part of the COC.

[Because this Amendment reflects changes in requirements of Federal law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.]

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the Certificate of Coverage (Certificate) in (Section 10: Glossary of Defined Terms) and in this Amendment below.

Maximum Policy Benefit/Limits on Essential Benefits

The Maximum Policy Benefit provision and the definition of Maximum Policy Benefit in the Certificate and all references to a Maximum Policy Benefit are deleted. Benefits under the Policy are not limited by a Maximum Policy Benefit.

Group [text] Include if the plan will not use restricted annual limits.
Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. [In addition, any annual dollar limit applicable to the essential benefits listed below is no longer applicable.] Essential benefits include the following:

Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all Benefits.

Group [Para] Include if the plan will use a restricted annual limit for all essential benefits.
[Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:

- For plan or Policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000.

- For plan or Policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1,250,000.
- For plan or Policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2,000,000.
- For plan or Policy years beginning on or after January 1, 2014 there will be no annual dollar limit on essential benefits.]

Group [Para] Include for non-grandfathered plans and any grandfathered plan that will have this benefit added.

¹Include for Choice Plus and Select Plus. Do not include for Choice or Select.

[Preventive Care]

[¹Network] Benefits for preventive care that are payable at 100% of Eligible Expenses (without application of any Copayment or Annual Deductible) apply to the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.]

Group [Para] Include when plan design applies a pre-existing condition exclusion.

[Preexisting Conditions]

[Preexisting condition exclusions do not apply to Covered Persons under age 19. The preexisting condition exclusion in the Certificate, (Section 2: What's Not Covered - Exclusions) is replaced with the following:

[K.] [Preexisting Conditions]

Group [Para] A 12-month preexisting condition exclusion applies to all covered persons age 19 and older.

- [1.] [Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to Covered Persons under age 19.]

Group [Para] A 12-month preexisting condition exclusion applies to timely adds and an 18-month preexisting condition exclusion to late enrollees.

- [1.] [Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:
- The date you have had Continuous Creditable Coverage for 12 months.
 - The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to Covered Persons under age 19.]

Group [Para] A preexisting condition exclusion applies to late enrollees only.

- [1.] [Benefits for the treatment of a Preexisting Condition are excluded for Late Enrollees until the date you have had Continuous Creditable Coverage for [12] [18] months. This exclusion does not apply to Covered Persons under age 19.]]

Dependent Children

The following Dependent Child Special Open Enrollment provision is added to the Certificate, (Section 4: When Coverage Begins):

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

All references to Full-time Student status requirements are deleted. The definition of Dependent is replaced with the following:

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. [All references to the spouse of a Subscriber shall include a Domestic Partner.] The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the Service Area or have reasonable access to the Service Area.

The definition of Dependent is subject to the following conditions and limitations:

Group [text] ¹Available to include for grandfathered plans that apply this eligibility condition (only until 01-01-2014).

- A Dependent includes any child listed above under [26 - 30] years of age [¹who is not eligible to enroll in an eligible employer-sponsored health plan (as defined by law)].
- A Dependent includes an unmarried dependent child age [26 - 30] or older who is or becomes disabled and dependent upon the Subscriber.

[A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age [26 - 30].]

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

[A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.]

Fraud or Intentional Misrepresentation of a Material Fact

The terminating provision for Fraud, Misrepresentation or False Information in the Certificate, (Section 8: When Coverage Ends) is replaced with the following:

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

Ending Event	What Happens
Fraud or Intentional Misrepresentation of a Material Fact	<p>You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.</p> <p>During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.</p>

Claims and Appeals

Other changes provided for under the PPACA impact how claims and appeals are handled and are applicable to your plan

- You have the right to appeal a rescission of coverage determination.
- If any new or additional evidence is relied upon or generated by us during the determination of an appeal we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.
- With respect to any urgent request for Benefits you will receive the notice of benefit determination within 24 hours after we have received all necessary information.

Product Design [Para] Include when the state does not have the required external review process in place.

- [The Departments of Health and Human Services, Labor and Treasury (Departments) will establish a Federal external review process which will be available in those jurisdictions where no State external review process is in effect. Where applicable, once the process has been established by the Departments we will provide you with additional information concerning the process.]]

Other changes provided for under the PPACA:

Other changes provided for under the PPACA do not impact your plan because your plan already contains these provisions. These include:

- Direct access to OB/GYN care without a referral or authorization requirement.
- The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.

- The ability to designate any primary care physician (PCP) that is accepting new patients.
- Prior authorization is not required before you receive services in the emergency department of a Hospital.
- If you seek emergency care from Non-Network providers in the emergency department of a Hospital your cost sharing obligations (Copayments) will be the same as would be applied to care received from Network providers.

Plan [Para]

Contract Issuance: Include Effective Date only if Amendment is to be mailed separate from the COC. Do not include effective date when amendment is issued as part of the COC.

[Effective Date of this Amendment: _____]

(Name and Title)

SERFF Tracking Number: UHLC-126803176

State: Arkansas

Filing Company: UnitedHealthcare of Arkansas, Inc.

State Tracking Number: 46730

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: 2001 PPACA Amendment

Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification	Approved-Closed	09/16/2010
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	09/16/2010
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	09/16/2010
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	09/16/2010
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: PPACA Uniform Compliance Summary	Approved-Closed	09/16/2010
Comments:		
Attachment: viewFilingAttachment.pdf		

SERFF Tracking Number: UHLC-126803176

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State Tracking Number: 46730

Company Tracking Number:

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: 2001 PPACA Amendment

Project Name/Number: /

	Item Status:	Status
Satisfied - Item: Cover Letter	Approved-Closed	09/16/2010
Comments:		
Attachment:		
PPACA Filing Cover Letter Final.pdf		

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ INDIVIDUAL HEALTH BENEFIT PLANS (Complete [SECTION A](#) only)

☐ SMALL / LARGE GROUP HEALTH BENEFIT PLANS (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
				<input type="checkbox"/> Yes <input type="checkbox"/> No

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services. Explanation: Page Number:	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. Explanation: Page Number:	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Appeals Process – Requires establishment of an internal claims appeal process and external review process. Explanation: Page Number:	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level. Explanation: Page Number:	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network. Explanation: Page Number:	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology. Explanation: Page Number:	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes [◇] <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

◇ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
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	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			



September 06, 2010

Rosalyn Minor

Arkansas Insurance Department

1200 West 3rd Street

Little Rock, Arkansas 72201

Re: UnitedHealthcare of Arkansas, Inc.

NAIC No. 95446

Patient Protection and Affordable Care Act (PPACA) Amendment
[PPACAAMD.[H].[01].AR]

Flesch Score: 53.1

Dear Ms. Minor:

On behalf of UnitedHealthcare of Arkansas, Inc., I am submitting the enclosed group health amendment for your Department's review and approval. We are requesting to use this amendment in conjunction with our approved [2001] product series, form filing [Policy.[H].[01].AR] et al. This amendment is being filed to incorporate the requirements as required under the Patient Protection and Affordable Care Act (PPACA).

We are committed to supporting and complying with the new health care reform provisions and working to help our customers make changes that better manage rising health care costs. UnitedHealthcare has had a long standing commitment to prevention and wellness. We have rich plan offerings that help our members with their health and well-being needs. Many of our plans currently offer a 100% preventive care benefit. We are adding 100% preventive care to all Fully Insured plan designs as of their first renewal on or after September 23, 2010.

For groups [1 - 99] we will apply all health care reform compliant provisions (100% preventive benefits, appeals process, access to OB/GYN, and pediatricians as PCPs) to all Fully Insured plan designs in the [1- 99] segment. All new business and renewals on or after 9/23/2010 will be compliant with the new health care reform provisions. No exception or opt-out process will be available

For groups 99+ we will apply all health care reform compliant provisions (100% preventative benefits, appeals process, access to OB/GYN, and pediatricians as PCPs) to all 99+ Fully Insured plan clients. Existing clients will be presented with health care reform compliant plans at renewal on or after 9/23/2010.

Revisions made to comply with the PPACA are described below:

- Maximum Policy Benefit/Limits on Essential Benefits:
 - As a standard we will not be imposing any Maximum Policy Benefit on Essential Benefits due to the restriction under PPACA on lifetime limits. All references to Maximum Policy Benefit have been removed.

- Annual benefit limits on benefit categories that meet the federal definition of Essential Benefits no longer apply, except for those plans that opt to apply the federally defined "restricted annual limits" on Essential Benefits. Those restricted annual limits are described as variable options in the amendment.
- Preventive care services are provided at 100% Preexisting condition exclusions no longer apply to covered persons under the age of 19.
- Enrolled dependent children are now covered up to age 26 regardless of marital or student status.
- Dependent Children/Dependent Child Special Open Enrollment Period provision added to allow the required 30 day opportunity for those children who are not currently enrolled at the time of renewal and have not met the limiting age of 26.
- Former provision entitled Fraud, Misrepresentation or False Information provision re-titled and language clarified to limit rescission only to instances of fraud or intentional misrepresentation of a material fact.
- The following provisions are added, specific to claims and appeal rights:
 - Right to appeal a rescission of coverage determination
 - Right of covered persons to access new or additional evidence that was relied upon or generated by us during a determination of an appeal.
 - Right to notice of benefit determination within 24 hours for urgent request for benefits.
 - The inclusion of a federal external review process.
- Other Changes Provided for Under PPACA section explains those provisions, such as direct access to a OB/GYN, required by PPACA that are already provided under the plan.

Our intent is to use this amendment for large and small employer groups and we request that your review encompass both.

Our intent is to use this form to convey deletion of, addition of, or change in the specifics of a provision previously filed with your Department.

Explanation Variable Text

Included in this amendment are the following features:

- Non-variable Text that always appears in an issued document.
- Variable Text that may or may not appear in an issued document depending on the specific product and plan design selected by the Enrolling Group. Variable text is enclosed in [brackets].
- Instruction text that is included, where necessary, to further explain the variability in the filed forms. Please note that any instruction text will appear only in the filed form and will not appear in the form issued to a member. Below are two examples of such instruction text.

1Include if the plan will not use restricted annual limits.

1Include for Choice Plus and Options PPO. Do not include for Choice or Non-Differential PPO.

Information contained within this form may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online viewing or issuance. We want to assure the Department that education will be provided to the brokers, employer groups and the employees regarding access and alternatives to electronic issuance.

This submission has been submitted electronically via SERFF and United Healthcare of Arkansas, Inc. recognizes that we may not implement this form until and unless approval has been granted. Should the

Department have any immediate concerns or questions regarding this submission, please feel free to contact me at 301.632.8056, through the SERFF messaging system or at Ebony_N_Terry@uhc.com.

Sincerely,

Ebony N. Terry